

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **ANCA M. MARAS, M.D.**

4 Holder of License No. 13103
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-03-0437A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Decree of Censure & Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on August 11, 2005. Anca M. Maras, M.D., ("Respondent") appeared before the Board
9 with legal counsel Joseph A. Kendhammer for a formal interview pursuant to the authority
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following
11 findings of fact, conclusions of law and order after due consideration of the facts and law
12 applicable to this matter.

13 **FINDINGS OF FACT**

14
15 1. The Board is the duly constituted authority for the regulation and control of
16 the practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of License No. 13103 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-03-0437A on January 22, 2003 after
20 Banner Desert Medical Center ("Banner") notified the Board it had suspended
21 Respondent's privileges and required her to undergo the Physician Assessment and
22 Clinical Education ("PACE") program prior to Banner considering restoring her privileges.
23 Respondent applied to undergo the PACE assessment in January 2004, but as of
24 September 2004 had not attended the assessment. On September 2004 the Board
25 issued an Interim Order for Evaluation requiring Respondent to undergo a PACE
assessment. Respondent presented to PACE on December 21 and 22, 2004 for the two-

1 day assessment and returned to PACE on February 7 through 11, 2005 for the additional
2 five-day clinical education program.

3 4. The allegations forwarded by Banner included that Respondent's rate of
4 epidural blood patch and re-patch following labor epidurals and spinal anesthesia was
5 above both the national average and the average of her peers; that her privileges were
6 suspended for quality of care issues including increased patient pain and suffering,
7 extended hospital stays and readmissions, and lower patient satisfaction; that
8 Respondent failed to document her anesthesia care in a legible and understandable
9 manner; that Respondent negligently performed labor epidurals and spinal anesthesia
10 requiring an above average rate of epidural blood patch; that Respondent failed to
11 employ basic anesthesia monitoring, such as use of a Capnograph; that Respondent
12 failed to seek assistance in complicated cases; that Respondent failed to use invasive
13 monitoring modalities when indicated; that Respondent improperly prescribed
14 medications; and that Respondent failed to appropriately recognize and treat
15 complications.

16 5. An outside Medical Consultant reviewed the records and opined that there
17 were multiple deviations from standard anesthesia care. Specifically, the Medical
18 Consultant found Respondent failed to have the Capnograph functioning during
19 intubation resulting in a failure to timely detect esophageal intubation; Respondent failed
20 to monitor the temperature of a patient using current modalities who was receiving a
21 massive blood transfusion; and in performing epidural anesthesia Respondent failed to
22 recognize or document wet taps and performed more than the usual number of epidural
23 blood patches resulting in concern over the frequency of repeated patches used on the
24 same or subsequent day with the production of pneumocephalus in two patients. The
25 Medical Consultant opined Respondent has difficulty employing invasive monitoring

1 modalities when indicated, such as placing central venous lines and arterial lines. The
2 Medical Consultant specifically mentioned Respondent's breaking a guide wire in one
3 case and failure to start lines in others.

4 6. The Medical Consultant also opined that Respondent employed stronger
5 than currently recommended concentrations of anesthetic agents in providing epidurals,
6 resulting in high block and requiring ventilation by an Ambu bag; that she ordered
7 medication without examining the patient, and used excessive doses of Pentothal for
8 induction in hemorrhaging patients. The Medical Consultant also opined that
9 Respondent failed to recognize and appropriately treat complications, including over
10 transfusing patients with DIC and failing to timely recognize an esophageal intubation.

11 7. The PACE report notes Respondent had a satisfactory knowledge base and
12 can return to the practice of anesthesia. Respondent accrued approximately 60.25 hours
13 of continuing medical education during the three months prior to her Phase One PACE
14 assessment. There are eleven portions of the Phase One evaluation. On the basis of
15 that evaluation Respondent was asked to return for the Phase Two five-day clinical
16 education program in the Department of Anesthesiology to more thoroughly evaluate her
17 clinical knowledge and judgment. Respondent completed Phase Two and was
18 determined to have a satisfactory knowledge base. Respondent took and passed a final
19 examination and PACE faculty agreed she made significant improvements to her
20 knowledge base and approach to anesthetic management.

21 8. Respondent noted her prior history before the Board. Respondent testified
22 she is a safe physician and is not a danger to her patients and the PACE evaluation
23 proved this. Respondent testified the cases came to the Board from Banner as a result
24 of anti-competitive behavior in the obstetrics and gynecology department.

25

1 9. The Board noted that all of the allegations against Respondent revolve
2 around two basic issues: documentation and medical management of patients.
3 Respondent testified when she practiced anesthesia she did between eight hundred and
4 one thousand cases per year and sixty to seventy percent were obstetrical cases with the
5 remainder being gynecological cases. Respondent testified her cases represented the
6 average patient population, size, and complications, but then indicated she did get a
7 large amount of complicated cases that were refused by other anesthesiologists.
8 Respondent testified that after she completed a full consent about what could happen in
9 a complicated case (blood patch, spinal wet tap, or post-epidural headache) she would
10 do the case.

11 10. Respondent was referred to the records of patient KT, specifically page
12 three of the anesthesia records dated January 8, 2001. Respondent was asked to
13 explain the entry after "CLE" (continuing lumbar epidural). Respondent testified it said
14 "Lidocaine 1.5% 3ccs" then "Bupivacaine." Respondent was asked if the "3" indicated a
15 dosage or a reference to her comments down at number three. Respondent testified the
16 "3" indicated the dose. Respondent was asked where the dosage was indicated for the
17 quarter percent Bupivacaine. Respondent testified she did not write it down and at that
18 point went farther at 17 and at that time she only used Lidocaine and Fentanyl 50 mics.
19 Respondent testified she did not use local anesthetic because KT did not need it. The
20 Board clarified that Respondent used five ccs of Fentanyl as her anesthetic. Respondent
21 said she had not and the record should be read as "50 mics." Respondent was asked if
22 this was a usual dose for a late epidural. Respondent testified that according to KT's
23 pain level there was no need for more than that and she can start with Lidocaine in early
24 labor and then continue with local anesthetic in different concentrations.

1 11. Respondent was asked if it was her testimony as a board certified
2 anesthesiologist that it is typically adequate in a pre-eclamptic, obese patient in late
3 Stage 1 labor to do a 3 cc test dose of one and one-half percent Lidocaine and 50
4 micrograms of Fentanyl. Respondent testified it was adequate. Respondent noted if a
5 patient is two or three centimeters or even one centimeter and complains of pain and
6 Respondent has the obstetrician's indication that the epidural can start, she starts with
7 opioids to alleviate pain and then supplements farther along the road, more Lidocaine or
8 more of whatever local anesthetic she wants. Respondent noted the approach of opioid
9 as an initial medication is not standard of care, but is a judgment call considering the
10 patient's status. Respondent stated that if the Board looked at the dilation of KT it would
11 see she was two centimeters and more anesthetic was not needed.

12 12. Respondent was directed to the lower part of the chart under "aseptic
13 conditions at L2-3." The Board indicated there was an arrow going to something, but it
14 could not read what it said. Respondent testified it said "L1 and 2. Obese. Nervous."
15 Respondent testified it indicates she was not successful at L2-3 so she went higher to L1-
16 2 and then put "okay." Respondent stated her notes were very symbolic, but that is what
17 she did. The Board noted KT's chart was very difficult to read. The Board noted KT
18 ended up with a posterior puncture headache and pneumocephalis. Respondent testified
19 this was correct. The Board noted KT's anesthesia record has no mention of
20 complications of any sort. Respondent testified this was correct and stated the Board
21 was right about her charts that the Board could not understand them, but noted she did
22 not have any problems with understanding from her experts that looked at the charts.
23 Respondent testified labor and delivery charts are not created for anesthesia and she has
24 to be creative and put in whatever she considers is pertinent. Respondent indicated KT's
25 record was a regular anesthesia record that has limitations and she wrote what she can

1 explain, and will explain later what happened with the wet tap. Respondent testified if
2 she does an epidural she will not always be able to identify a wet tap because of the tip of
3 the needle and the way the catheter goes in, the tip of the needle is bent and can nick or
4 perforate the dura without giving her any feedback. Respondent testified she puts the
5 catheter in and takes a curvature of the needle; the catheter takes a position in the right
6 space, without giving her the wet tap. Respondent testified the only way she can
7 appreciate she has a problem is post-op when the patient complains and KT had many
8 different causes for the headache so that is why she did not do it in the beginning, the
9 blood patch, and then whenever the symptomatology was obvious, she did.

10 13. The Board noted the confusion in KT's case is that there were a number of
11 days while working up a headache that a CT scan was done that revealed KT had
12 pneumocephalus. Respondent was asked how, by looking at her chart, would the
13 obstetrician or neurologist see Respondent had difficulty placing the epidural when the
14 record only shows she went from L2-3 to L1-2. Respondent testified her chart shows the
15 time she started the epidural as 11:30 and the medication time shows 11:50 and since an
16 epidural usually takes five minutes to place, the fact that it took her twenty minutes to
17 place indicates she had difficulty. The Board noted Respondent was expecting other
18 physicians to make an assumption and that a neurologist would probably have no idea
19 how long it takes to place an epidural in the spine.

20 14. Respondent was directed to the records of patient LS. The Board indicated
21 it could not read the drugs listed after Lidocaine. Respondent testified it was
22 Bupivacaine, 25% and Duramorph. Respondent was directed to the bottom of the chart
23 where the Board was having difficulty reading the chart. Respondent testified it said
24 "continual lumbar epidural requested by patient. L1-2 very difficult to insert" and "back
25 pain" is in parentheses – that was the patient's comment. Respondent was asked if this

1 was a combined spinal epidural as indicated by the record stating "CLE/CSE."
2 Respondent testified it was only an epidural that was started before the surgery.
3 Respondent was directed to the record where she wrote the needle size as 17 gage and
4 then "CSE (25)" and asked whether that meant she used a 25 gage spinal needle during
5 CSE. Respondent testified she used a combined spinal epidural needle to identify the
6 spinal compartment or subarachnoid and she continued the lumbar epidural.
7 Respondent was asked if it was correct that typically the Tuohy (17 gage) needle goes in
8 first. Respondent testified that with a combined spinal she locates the epidural space
9 and then, when she is sure she is there, she inserts the spinal needle to put medications
10 or not. Respondent was asked why she would put a spinal needle when she was not
11 certain she would put the medications. Respondent testified you have to continue that
12 test dose and opiate and then retract and place the epidural in the epidural space.
13 Respondent noted you can localize the spinal with no intention to do a spinal and then
14 continue with the epidural.

15 15. The Board asked for clarification and asked if Respondent put in the
16 epidural as usual with her combined technique needle then put her spinal needle through
17 the epidural. Respondent testified she had. Respondent was asked if she identified
18 spinal space by spinal fluid and then did not inject medication into the spinal space.
19 Respondent testified if she does a combined spinal epidural you inject medication in the
20 spinal needle and then take it out and continue to place the epidural catheter.
21 Respondent was asked whether or not she did a spinal anesthetic in LS. Respondent
22 testified she did an epidural. Respondent was asked whether or not she put a spinal
23 needle into LS's subarachnoid space. Respondent testified she did not. Respondent
24 testified the Board had to understand if she continued to have this case, in order to do a
25 spinal for a C-section, she goes into the operating room and performs that because a

1 combined spinal epidural can be in the labor room or in the recovery room. Respondent
2 testified she used to place epidurals for C-sections in the recovery room and transport the
3 patient in the operating room. Respondent was asked if her testimony was that she
4 confirmed a Tuohy needle epidural placement by placing a spinal needle into the
5 subarachnoid space without medication. Respondent testified it was not her testimony
6 because she was confused and she had to read the whole chart to see why she did that.
7 Respondent testified the Board had to take into consideration LS's size, her scoliosis,
8 and her concern with her previous anesthesia experience that was not pleasant and the
9 obstetrician specifically requested she do this case.

10 16. Respondent was directed to the records of patient LM. The Board noted
11 the chart was difficult to decipher and asked Respondent if she performed a spinal or an
12 epidural. Respondent testified it was a spinal because of .75 spinal medication and that
13 is used only for obstetrics. The Board noted physicians typically write in the procedure
14 that they used local anesthetic versus what is in the subarachnoid space in this particular
15 case and Respondent's charts were very confusing.

16 17. The Board indicated it wanted to focus on Respondent's medical
17 management and directed her to the records of patient KC. KC had a delivery with
18 bleeding, postpartum hemorrhage and hysterectomy post delivery. Respondent was
19 directed to the particular anesthetic chart where the patient went back to surgery because
20 of hemorrhaging. Respondent was asked her normal dose range for Pentothal on a
21 patient. Respondent testified it was between two and four milligrams. The Board noted
22 KC had a pregnant weight of 175 pounds (eighty kilos). Respondent was asked if she
23 agreed that 4-6 milligrams is recommended in obstetrics, with four milligrams on the
24 lower side of total body weight, and if so, KC would be around 320 milligrams of
25 Pentothal and Respondent used 500 milligrams. Respondent testified the Board was

1 missing that KC was in labor, she had an epidural level and it happened two hours after
2 she was in the recovery room. Respondent testified KC was already fully dilated and was
3 bleeding, but her vital signs were stable and Respondent gave enough fluids to be able to
4 induce her with Pentothal. Respondent testified she did not just shove the 500 milligrams
5 into KC and after giving at least half the syringe KC was still awake. Respondent testified
6 she titrated as fast as she could under the circumstances and KC was still awake when
7 she gave the rest. Respondent testified KC was very aware, hemodynamically prepared
8 up to that point.

9 18. Respondent was asked where in the chart she indicated she incrementally
10 gave the Pentothal because the chart shows only 500 milligrams of Pentothal and that
11 would indicate a bolus dose. Respondent testified KC's vital signs show she gave the
12 dose incrementally; that if she had given a bolus dose KC's blood pressure would have
13 dropped and it did not. Respondent was next directed to the amount of transfusion. The
14 Board summed up Respondent's testimony as saying she believed she had a stable
15 patient who had a blood loss of approximately 1200 ccs that prompted the surgeon to be
16 concerned enough to go back to surgery. The Board noted Respondent stated for the
17 record that she felt with a Pentothal dose KC was euvolemic and therefore did not drop
18 her blood pressure. The Board noted during the second operation KC lost approximately
19 600 ccs and in the PACU she lost another 2,000 ccs and Respondent gave twenty units
20 of packed cells, approximately six liters of total blood volume. The Board calculated a
21 total blood loss of approximately 4,000 ccs and asked Respondent how many units of
22 blood that was in her calculation. Respondent testified it was sixteen, but asked what the
23 question was. The Board went back a bit and asked Respondent how she typically
24 transfused a patient – how much blood loss and how much packed cells she would give a
25 patient for blood loss. Respondent testified she would calculate blood volume, calculate

1 the hematocrit and then she says 30% hematocrit is what she wants to reach before
2 transfusing, but KC was different because she was bleeding and not coagulating.
3 Respondent testified the only thing is to maintain KC's oxygen and carrying capacity and
4 her platelets and whole coagulants. Respondent testified she had to transfuse and knew
5 she could over transfuse, but versus having a dead patient on the table, that happened in
6 DIC, she chose that line. Respondent testified she tried everything – tried to place a
7 central line and got a hematoma and had to have a nurse with an ice bag on KC's neck to
8 make the situation better. Respondent testified she tried a radial artery on the left hand
9 and it was not accessible so she gave up. Respondent testified she called for help and
10 had a conversation with another physician and he said to infuse.

11 19. Respondent was asked if she agreed that KC received a very large amount
12 of blood cells along with other products and fluids that ultimately put her in the intensive
13 care unit intubated with pulmonary edema and fluid overload. Respondent agreed.
14 Respondent was asked to put together her testimony that KC was stable yet Respondent
15 was giving her large amounts of blood. Respondent testified KC was bleeding and was
16 in DIC and both surgeons were concerned she was not coagulating. Respondent
17 testified the Board was right looking at this retrospectively.

18 20. Respondent was directed to the medical records of patient LO.
19 Respondent was asked about the issue of the End Tidal CO2 monitor and why this
20 patient was not an emergency dash back to the operating room. Respondent testified LO
21 was an elective case and general anesthetic was selected because of the difficult shunt
22 and the indication from her neurologist not to patch her back. Respondent testified she
23 performed a labor epidural under the same circumstances on the back one year prior and
24 it went okay, but now LO came with the indication or recommendation not to use any
25 spinal or any block. Respondent was asked to go briefly through her machine checks.

1 Respondent testified she has everything put in the operating room, in the labor C-section
2 room, to start an emergency situation. Respondent states she checked the oxygen high
3 and low, the heart monitor put on position, temperature probe easy to insert, blood
4 pressure arm board, EKG, ready to go. Respondent noted the medication she used was
5 ready to go, but because of certain recommendations she had to prepare it before.
6 Respondent was asked if the End Tidal CO2 monitor was placed on "sleep." Respondent
7 testified it was on. Respondent was asked if she saw the End Tidal CO2 when she
8 intubated LO. Respondent testified she did not see anything, it was on and it was no CO-
9 2 wave. Respondent testified on the first try the tube was difficult and she realized she
10 needed help. Respondent testified the labor and delivery nurse tried to help, but was not
11 helpful and she called for help that did not come so she took the tube out and ventilated
12 by mask. Respondent testified she needed an anesthesiologist to help and they refused
13 to come. Respondent testified she was not able to ventilate, tried to compare what she
14 got with her own bad ventilation, the previous wave; but she did not have that so by
15 mistake she put the CO2 monitor on sleep mode.

16 21. Respondent was asked if the tube was out. Respondent testified it was out
17 the first time she ventilated and she inserted it a second time by adjusting the position
18 and holding it in a different way, she started with a needle the second time and called for
19 code. Respondent testified she continued to put the tube in, it was not in and she turned
20 from "sleep" to on and took the tube out. Respondent testified another physician arrived
21 and he could not get the tube in the first time, but was successful on the second attempt.
22 Respondent testified at no time was it an unrecognized esophageal intubation.

23 22. Respondent was redirected to KT, the patient with the lumbar puncture.
24 Respondent was asked why she started at L2-3. Respondent testified it was the biggest
25 epidural space – it is 4-5, 2-3 and then it will go smaller. Respondent testified she felt the

1 bone better and could position KT so she could feel the bone better. Respondent was
2 asked where the spinal cord ended and indicated at L2-L3. The Board indicated there
3 may be variations, but generally the spinal cord ends at L1-L2. Respondent was asked
4 to confirm that she put a 17 gage Tuohy needle in the epidural space. Respondent
5 testified she put it under local position in the air locating, she locates it and she thinks she
6 is all right, although there are false spaces, and then when she thought she was in the
7 space, she rotates the needle. Respondent was asked if she then inserted the other
8 needle. Respondent testified she did insert the other needle in the subarachnoid space
9 such that she would go at least one or 50 millimeters or one and one-half centimeters
10 behind the tip.

11 23. The Board noted if Respondent hit the spinal cord the patient would be in
12 pain and asked Respondent the complications of hitting the spinal cord. Respondent
13 testified it depended on how persistent she was and the patient will tell her that it is very
14 painful and she will take it out. The Board noted the object was to not hit the spinal cord
15 and the reason a spinal tap was not done at L1-2 is because of possible injury to the
16 spinal cord. Respondent disagreed and testified that because she has patients that need
17 to have the pump or pain medication higher she taps at L1-2, but does it carefully.

18 24. Respondent was required to keep adequate medical records. Adequate
19 medical records are legible medical records that contain, at a minimum, sufficient
20 information to identify the patient, support the diagnosis, justify the treatment, accurately
21 document the results, indicate advice and cautionary warnings provided to the patient
22 and provide sufficient information for another practitioner to assume continuity of the
23 patient's care at any point during the course of treatment. A.R.S. § 32-1401(2).

24 25. The standard of care required Respondent to employ basic anesthesia
25 monitoring, including a capnograph, in order to timely detect esophageal intubation; to

1 seek assistance in complicated cases; to use invasive monitoring modalities where
2 indicated; to properly use medications; to recognize complications and treat them
3 accordingly.

4 26. Respondent deviated from the standard of care because she failed to
5 employ basic anesthesia monitoring in order to timely detect esophageal intubation; she
6 failed to seek assistance in complicated cases; she failed to properly employ invasive
7 monitoring modalities; she failed to use the recommended concentrations of anesthetic
8 agents in providing epidurals and used excessive doses of Pentothal to induce a
9 hemorrhaging patient; she failed to monitor a patient's temperature using current
10 modalities when the patient received a blood transfusion; and she failed to recognize or
11 document "wet tap."

12 27. KT and LS were harmed because they suffered from pneumocephalis. KC
13 was harmed because she was over transfused and hydrated and developed pulmonary
14 edema, respiratory failure and other life threatening complications. KC was also
15 subjected to potential harm by Respondent's administration of an excessive potentially
16 fatal dose of an anesthetic agent. LO was harmed by an esophageal intubation.
17 Respondent's patients were also subjected to potential harm.

18 28. The Board noted Respondent's prior record with the Board and her failure
19 to see problems with her conduct as aggravating factors. The Board noted Respondent's
20 successful completion of PACE as a mitigating factor.

21 **CONCLUSIONS OF LAW**

22 1. The Arizona Medical Board possesses jurisdiction over the subject matter
23 hereof and over Respondent.
24
25

1 B. Respondent may apply to the Board in two years to have the probation
2 lifted.

3 C. Respondent shall practice in a group setting that allows effective
4 consultation when needed for patient safety.

5 D. Respondent shall be subjected to random periodic chart reviews to assure
6 adequate documentation.

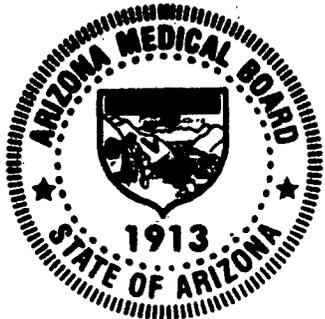
7 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

8 Respondent is hereby notified that she has the right to petition for a rehearing or
9 review. The petition for rehearing or review must be filed with the Board's Executive
10 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
11 petition for rehearing or review must set forth legally sufficient reasons for granting a
12 rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days
13 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
14 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
15 Respondent.

16 Respondent is further notified that the filing of a motion for rehearing or review is
17 required to preserve any rights of appeal to the Superior Court.

18 DATED this 13th day of October, 2005.

19
20 THE ARIZONA MEDICAL BOARD



By 
TIMOTHY C. MILLER, J.D.
Executive Director

1 ORIGINAL of the foregoing filed this
2 13th day of October, 2005 with:

3 Arizona Medical Board
4 9545 East Doubletree Ranch Road
5 Scottsdale, Arizona 85258

6 Executed copy of the foregoing
7 mailed by U.S. Certified Mail this
8 13th day of October, 2005, to:

9 Joseph A. Kendhammer
10 Kendhammer & Colburn, LLP
11 394 North Third Avenue
12 Phoenix, Arizona 85003-0001

13 Anca M. Maras, M.D.
14 Address of Record

15 *Anca M. Maras*